Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers participating in the Virginia Medical Assistance Program

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO Special
DATE 10/28/2003

SUBJECT: Changes in Billing for Medicare "Crossover" Claims

The Department of Medical Assistance Services (DMAS) is in the process of enhancing our Medicaid Management Information System (MMIS) so that all claims submitted to Medicaid for payment after they have been processed by Medicare are paid correctly and consistent with State and federal guidelines. The principal change being made is to ensure that the Medicaid reimbursement for Medicare claims, in combination with the Medicare payment, does not exceed Medicaid allowed amounts. The modifications to the MMIS will be implemented on December 1, 2003, and for some providers will require changes to the billing procedures for paper Medicare claims postmarked after November 21, 2003. Please read this Memo carefully to ensure that you are aware of how these claims will be paid and that you are prepared for the new procedures.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid recipients who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid, in combination with the Medicare payment, will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

In order to collect all of the information needed to calculate the amount Medicaid will pay for Part A and outpatient hospital services, DMAS will begin to require that these services be submitted on a UB-92 claim form when a paper claim form is filed.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible recipients are automatically submitted to DMAS by the Medicare claims processors (fiscal intermediaries and carriers) based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

There are no changes in the process for the automatic submission of Medicare claims from the Medicare fiscal intermediaries. These claims will continue to be submitted on your behalf by the Medicare claims processors and will be priced according to the Medicaid reimbursement rules described in this Memo.

DMAS provides information about dually eligible (Medicaid and Medicare) recipients to the following Medicare fiscal intermediaries and carriers. If you submit your claims to any of the following, your claims should be automatically crossed over to Medicaid.

- United Government Services
- AdminaStar Federal
- Palmetto GBA
- Trailblazer Health Enterprises, Part A
- Trailblazer Health Enterprises, Part B

Please note that this process will work correctly **only** if DMAS has your Medicare vendor number on file. Your Medicare-assigned vendor number is added to our Medicare cross-reference file, which links the Medicare vendor number to your Medicaid provider number when crossover claims are received from the Medicare intermediaries and carriers. If we are unable to associate the Medicare vendor number on the crossover claim with a valid Medicaid provider number, the claim is held and recycled for 180 days until a match is found. If a match cannot be made after 180 days, the claim is denied.

The vendor number on the file maintained by Medicaid that links to the Medicare vendor number in the claims file received from Medicare must be the rendering provider's individual Medicare number. If the Medicare group number is on a claim, it must also be on the cross-reference file. All of the claims for the group will be paid under the single Medicaid provider number associated with the Medicare group number.

FILING YOUR MEDICARE VENDOR NUMBER WITH VIRGINIA MEDICAID

At the time of enrollment in Medicaid, a provider may not have a Medicare number assigned. If this is the case, save the Request for Title XVIII (Medicare) Information form contained in the enrollment package and mail or fax the form to our fiscal agent's, First Health Services Corporation, Provider Enrollment Unit as soon as a vendor number is assigned by Medicare. The form (which is included as an attachment to this Memo) may be copied for multiple enrollments, and you are requested to submit a form for each provider. The Title XVIII Information form is not a requirement, but its use is encouraged so that all of the required information and signatures are submitted to Medicaid. Please feel free to call the First Health Provider Enrollment Unit at any time to inquire about your Medicare/Medicaid enrollment and to verify that the information we have on file is correct. The Title XVIII form may also be printed from the Virginia Medicaid website at http://virginia.fhsc.com (do not enter www as part of the web address).

To contact the First Health Provider Enrollment Unit (PEU) you may call:

1-888-829-5373 (In-State) 1-804-270-5105 (Out-of-State)

Or, you may fax the Request for Title XVIII (Medicare) Information form to:

1-804-270-7027

Or, you may send your Request for Title XVIII (Medicare) Information form to:

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

SUBMITTING PAPER MEDICARE CLAIMS

If an electronic Medicare claim is not automatically crossed over to Medicaid, a provider can submit a paper claim. Claims for services previously billed to Medicare should be submitted using paper claims only under the following conditions:

- You submitted your Medicare claim to a Medicare fiscal intermediary or carrier other than those listed above. Please encourage your Medicare intermediary or carrier to contact First Health's Provider Enrollment Unit (PEU) to inquire about setting up automatic crossovers with Virginia Medicaid.
- You are re-filing a previously denied claim or adjusting a previously paid claim.
- You have contacted First Health's Provider Enrollment Unit and requested that your Medicare provider number be removed from the Medicare cross-reference file.
- You have not received notification that your claim has crossed over, and it has been more than 60 days since you received your Explanation of Medicare Benefits (EOMB).

DMAS utilizes several methods to research the exact reason that claims identified on your Medicare EOMB as "Crossed to Medicaid" may not appear on your Medicaid Remittance Advice. If you are experiencing this type of difficulty, please call First Health's Provider Enrollment Unit (in Virginia call 1-888-829-5373; out of Virginia call 1-804-270-5105) so that your specific problem can be researched before you resort to submitting a paper claim.

******Important Billing Form Changes******

To correctly calculate reimbursement for Medicare Part A and outpatient hospital claims, DMAS will begin requiring that paper claims for Part A and outpatient hospital services be submitted on a UB-92 claim form rather than the DMAS-30 Title XVIII Claim form currently used. Paper claims submitted to Medicaid for Medicare Part A and outpatient hospital services must be on the paper UB-92 form beginning for claims postmarked after November 21, 2003. **Any claims for Part A or outpatient hospital services postmarked after November 21, 2003 that are on the DMAS-30 Title XVIII Claim form will be returned, regardless of the date of service.** If you are unable to submit your Part A and outpatient hospital Medicare claims on the UB-92 by the above date, we ask that you hold your claims until they can be submitted on the correct form.

Billing instructions for using the UB-92 form to submit Medicare claims are attached. These instructions will be incorporated into the Medicaid Billing Manuals and posted to our website at a future date. Please use the attached instructions to begin submitting Part A and outpatient hospital paper claims beginning with claims postmarked after November 21, 2003, regardless of the dates of service.

Medicare Part B paper claims will continue to be submitted using the DMAS-30 Title XVIII Claim form, except for outpatient hospital services. Please note that the DMAS-30 Title XVIII Claim form should be sent as a claim, not as an attachment to a CMS-1500 claim. Sending it as an attachment will result in the CMS-1500 claim being denied with a message to bill Medicare first.

In the future, the DMAS-30 Title XVIII Claim form will be modified to reflect that it no longer is to be used for Part A claims. However, the current form can continue to be used for Medicare Part B services (other than outpatient hospital). DMAS–30 Title XVIII Claim forms can be obtained by calling the DMAS Order Desk at 804-780-0076 or faxing your order to 804-780-0198. Note that DMAS does not supply UB-92 claim forms.

PAYING MEDICARE CLAIMS

As mentioned previously, Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid recipients who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid, in combination with the Medicare payment, will not exceed the amount Medicaid would pay for the service if it was billed directly to Medicaid. In the event that the Medicare reimbursement equaled or exceeded the Medicaid reimbursement rate, your claim will be denied with reason 0364 (Primary carrier payment equals or exceeds DMAS' allowed amount).

In order to correctly process and reimburse Medicare claims, the Medicaid claims processing system must calculate the Medicaid allowed amount for the services identified on the claim. With few exceptions, a Medicare claim will be considered invalid if it does not contain the data needed to calculate the Medicaid allowed amount. These claims and the errors detected will be identified on your paper and/or electronic (835/U277) remittance.

It is understood that Medicare claims from Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) do not conform to normal Medicaid billing practices, in that Medicare claims are based on revenue code and Medicaid claims on procedure code. However, the Medicaid allowed amount for these facilities is equal to the Medicare allowed amount. So for Medicare claims from FQHCs and RHCs, the Medicaid allowed amount will be set to the Medicare allowed amount. Any claims for services not covered by Medicaid will be paid based on the coinsurance and deductible amounts submitted.

AUTOMATIC MEDICARE CROSSOVER PROBLEMS

DMAS has recently discovered that some dually eligible recipients are not being included in the eligibility files being sent to the Medicare fiscal intermediaries and carriers. This is resulting in claims not being automatically crossed over that should be, necessitating paper claims to be submitted. DMAS is working on a resolution to this problem, and we will have it resolved when the December eligibility files are created.

As stated previously, when crossover claims are processed by Medicaid, we need to match the Medicare vendor number to a valid Medicaid provider number. A Medicare vendor number can only be associated with one Medicaid provider number. For the crossover process to work correctly, the Medicare vendor number on the Medicare claim **must** be associated with the correct Medicaid provider number. If you are unsure whether your vendor number is known by DMAS, or if it is associated with the correct Medicaid provider number, please contact First Health's Provider Enrollment Unit (PEU) at the numbers listed above.

SUMMARY OF CHANGES

DMAS' MMIS is being enhanced effective December 1, 2003 to ensure that, whenever possible, claims that were previously processed by Medicare will be adjudicated so that the amount paid by Medicaid, in combination with the Medicare payment, will not exceed the amount Medicaid would pay for the service if it was billed directly to Medicaid. In general, Medicare claims will be expected to contain the information needed by the Medicaid system to apply its pricing rules. In the few cases where this cannot be done (i.e., claims for non-covered services), claims will be reimbursed using the submitted deductible and coinsurance amounts.

Most Medicare claims are automatically crossed over to Medicaid by a Medicare fiscal intermediary or carrier. If you are having problems with claims crossing over, or if you need to register your Medicare vendor number with Medicaid, please contact the First Health Provider Enrollment Unit.

If you need to submit a Medicare claim on paper, Medicare Part A and outpatient hospital claims must be on the UB-92 form beginning with claims postmarked after November 21 2003, regardless of date of service. Part B claims (other than outpatient hospital services) will continue to be submitted on the DMAS-30 Title XVIII Claim form.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its provider manuals and Medicaid Memoranda on the DMAS website at www.dmas.state.va.us. Refer to the Provider Column to find Medicaid and SLH provider manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273	Richmond area
1-800-552-8627	All other areas

Please remember that the "HELPLINE" is for provider use only.

Attachments

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE FOR PART A only

UB-92 Invoice Instructions for Medicare Part A Deductible and Coinsurance Billing

If payment is not received from Medicaid within 60 days of the Medicare payment, the provider should complete and submit the UB92 CMS-1450 claim form.

The following description outlines the process for completing the UB-92 CMS-1450 for **Medicare Part A** deductible and coinsurance. It includes Medicaid-specific information and should be used to supplement the material included in the *State UB-92 Manual*.

Locator		Instructions
1	**Required**	**Enter the provider's name, address, and telephone number.**
2	Unlabeled Field	
3	**Required** (if applicable)	**PATIENT CONTROL NUMBER** - Medicaid will accept an account number, which does not exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Refer to the UB-92 billing instructions in your Medicaid Provider Manual. * The proper use of these codes (see the *State UB-92 Manual*) will enable DMAS to reassemble cycle-billed claims to form DRG cases for purposes of DRG payment calculations.
5	Not Required	**FED. TAX No.**
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the beginning and ending service dates (in MM/DD/YY-MM/DD/YY format) reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. Refer to the UB-92 billing instructions in your Medicaid Provider Manual.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid-covered days as applicable. This should be the total number of covered accommodation days/units reported in Locator 46.
8	**Required**	**N-CD. (Non-Covered Days)** - Enter the days of care not covered for inpatient only. Non-covered days are not included in covered days. (Not required for outpatient rehabilitation agencies).

Locator		Instructions
9	Not required	C-ID. (Coinsurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	**Required**	**Enter the word "CROSSOVER"**
12	**Required**	**PATIENT NAME** - Enter the patient's name - last, first, and middle initial.
13	**Required**	**PATIENT ADDRESS** - Enter the patient's address.
14	**Required**	**BIRTHDATE** - Enter the month, date, and full year (MMDDCCYY).
15	**Required**	**SEX** - Enter the sex of the patient as recorded on the date of admission, outpatient service, or start of care.
16	**Optional**	MS (Patient's Marital Status)
17	**Required**	**DATE (Admission Date)** - Enter the date of admission for inpatient care. This date must be the same date for all interim claims related to the same admission. Enter the date of service for outpatient care.
18	**Required**	**HR (Admission Hour)** - Enter the hour during which the patient was admitted for inpatient or outpatient care.
19	**Required**	**TYPE (Type of Admission)** - For inpatient services only, enter the appropriate code indicating the priority of admission. A code "1" (emergency) indicates that a copay does not apply.
20	**Required**	**SRC (Source of Admission)** - Enter the appropriate code for the source of the admission. Code "7" (Emergency Room) indicates copay does not apply.
21	**Required**	**D HR (Discharge Hour)** - Enter the hour the patient was discharged from inpatient care.
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the ending date in Statement Covers Period (Locator 6). Correct reporting of the patient status code will facilitate quick and accurate determination of DRG reimbursement. In particular, accurate reporting of the values 01, 02, 05, and 30 will be very important in a DRG methodology.
23	**Required (if applicable)**	**MEDICAL RECORD NO.** - Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: This number should not be substituted for the Patient Control Number (Loc. 3 which is assigned by the provider to facilitate retrieval of the individual financial record).

Locator		Instructions
24-30	**Required (if applicable)**	**CONDITION CODES** - Enter the code(s) in numerical sequence (starting with 01) which identify conditions relating to this bill that may affect payer processing. Include the Special Program Indicator codes listed below, if applicable: A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION DANGER TO LIFE A8 INDUCED ABORTION VICTIM RAPE/INCEST
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing. This is important when billing for days that were exhausted by Medicare.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES** - Enter the code(s) and related dates that identify an event related to the payment of this claim. If code 71 is used, enter the FROM/THROUGH dates given by the patient for any hospital, skilled nursing facility (SNF), or nursing facility stay that ended within 60 days of this hospital admission.
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the claim ICN/reference number of the paid claim to be adjusted or voided. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). Be sure to use the appropriate type of bill (Locator 4) in combination with the reference number from the incorrect claim. NOTE: A=Primary Payer B=Secondary Payer C=Tertiary Payer Cross-Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	**Optional**	RESPONSIBLE PARTY NAME AND ADDRESS
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate codes to relate amounts or values to identified data elements necessary to process this claim. Line a **83 = Billed and Paid (enter amount paid by Medicare or other insurance).**

Locator		Instructions
		Line b **A1** = Deductible Payer A. **Enter Medicare Deductible Amount on the EOMB.** Line c **A2** = Co-Insurance Payer A. **Enter Medicare Co-Insurance amount on the EOMB.** **Note: Complete all information in Locators 39a through 41a first (payments by Medicare or other insurance) before entering information in 39b through 41b locators etc.**
42	**Required**	**REV. CD. (Revenue Codes)** - Enter the appropriate revenue code(s) for the service provided as follows: **CODE: Four digits, leading zero, left justified, if applicable.** See the Revenue Codes list under "Exhibits" in your provider manual for approved DMAS codes.
43	**Required**	**DESCRIPTION** - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the State UB-92 billing manual).
44	**Required (if applicable)**	**HCPCS/RATES** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered.
45	**Required (if applicable)**	**SERV. DATE** - Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges must include only covered charges. Note: Use code "0001" for TOTAL.
48	**Optional**	**NON-COVERED CHARGES -** Reflects non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "0001" for

Locator		Instructions
		TOTAL non-covered charges. (Enter the grand total for both total charges and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	
50	**A-C. Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. **NOTE**: If **Medicare** is the primary or secondary payer, enter **Medicare** on line A or B. If **Medicaid** is the secondary or tertiary payer, enter **Medicaid** on Lines B or C.
51	**A-C Required**	**PROVIDER NO.** - The **Medicare** and **Medicaid** Provider ID #. Enter the number on the appropriate line. A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information - Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits - Certification Indicator)
54	**A,B,C,P Required (if applicable)**	**PRIOR PAYMENTS** (Payers and Patients) <u>Long-Term Hospitals</u> - Enter the patient pay amount on "P" line as shown on the DMAS-122 Form furnished by the Local Department of Social Services Office. Note: A=Primary B=Secondary C=Tertiary P= Due from Patient **<u>DO NOT ENTER THE MEDICAID COPAY AMOUNT</u>**
55	A,B,C,P Not Required	EST AMOUNT DUE
56	Unlabeled Field	

Locator		Instructions
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**A-C Required**	**P. REL** - Enter the code indicating the relationship of the insured to the patient. Refer to the *State UB-92 Manual* for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT. - SSN - HIC - ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. NOTE: The Medicaid enrollee ID # is 12 digits.
61	**A-C Required (if applicable)**	**GROUP NAME** - Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable)**	**INSURANCE GROUP NO.** - Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.
63	Not Required	TREATMENT AUTHORIZATION CODES
64	**A-C Required (if applicable)**	**ESC (Employment Status Code)** - Enter the code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME** - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION** - Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD. (Principal Diagnosis Code)** - Enter

Locator		Instructions
		the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the ICD-9-CM diagnosis code(s) for diagnoses other than principal (if any). **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.** - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician. **DO NOT USE DECIMALS.**
77	**Required**	**E-CODE** (External Cause of Injury Code)
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 – HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**PRINCIPAL PROCEDURE CODE AND DATE** - Enter the ICD-9-CM procedure code for the major procedure performed during the billing period**. DO NOT USE DECIMALS.** For outpatient claims, a procedure code must appear in this locator when revenue codes 360-369, 420-429, 430-439, and 440-449 (if covered by Medicaid) are used in Locator 42 or the claim will be denied. For inpatient claims, a procedure code or one of the diagnosis codes of V64.1 through V64.3 must appear in this locator (or in Locator 67) when revenue codes 360-369 are used in locator 42 or the claim will be denied. Procedure code 8905 will be used by Virginia Medicaid if the locator is left blank. Procedures that are done in the Emergency Room (ER) one day prior to the recipient being admitted for an inpatient hospitalization **from** the ER may be included on the inpatient claim.
81	**A-E Required (if applicable)**	**OTHER PROCEDURE CODES AND DATES** - Enter the ICD-9 CM code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**
82	**Required**	**ATTENDING PHYS. ID.** <u>Inpatient</u>: Enter the number assigned by Medicare or

Locator		Instructions
		Medicaid for the physician attending the patient. Outpatient: Enter the number assigned by Medicare or Medicaid for the physician who performs the principal procedure.
83	Not Required	OTHER PHYS. ID.
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37).
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. (Required for paper claims only)
86	**Required**	**DATE** - Enter the date on which the bill is submitted to Medicaid. (Required for paper claims only)

The information may be typed or legibly handwritten. Mail the completed claims and attached EOMBs to:

Department of Medical Assistance Services
Title XVIII
P.O. Box 27441
Richmond, Virginia 23261-7441

Maintain the Institution copy in the provider files for future reference.

UB-92 (CMS-1450) Adjustment and Void Invoices:

- To adjust a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges.
  - Type of Bill (Locator 4) – The last digit of the bill type = 7 for adjustments
  - Locator 37 - Enter the claim ICN/reference number of the paid claim to be adjusted. The claim ICN/reference number appears on the remittance voucher.
  - Remarks (Locator 84) - Enter an explanation for the adjustment.

- To void a previously paid claim, complete the following data elements on the UB-92 CMS-1450:
  - Type of Bill (Locator 4) – The last digit of the bill type = 8 for voids.
  - ICN/DCN (Locator 37) - Enter the claim ICN/reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE FOR PART B only

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the 9-digit Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare) – Mark type of coverage B only.**

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission (if applicable)

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice for Part B only, DMAS-31 (Revised 6/96)

Adjustment Coinsurance Invoice, DMAS-31 (Revised 6/96)

The adjustment invoice is used to change information on a **paid** claim. This form cannot be used for the follow-up of denied or pended claims.

Void Coinsurance Invoice, DMAS-31 (Revised 6/96)

The void invoice is used to void the original payment. The information on the invoice must identical to the original invoice.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 2A **Reference Number** - Enter the reference number/*ICN* taken from the Remittance Voucher for the line of payment needing *an* adjustment. The adjustment cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Block 3 **Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.

Block 4 **Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 5 **Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.

Block 6 **Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance

provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate national place of service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

- **Accident** - Possible third-party recovery
- **Emergency** - Not an accident
- **Other** - If none of the above

Block 11 **Type of Service** - Enter the appropriate national code describing the type of service:

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code, which was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare.(Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and Disposition The information may be typed or legibly handwritten. Mail the completed claims and attached EOMBs to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

Retain a copy for the office files.